Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

Preliminary

Name of Hospital:		Medicare Provider Number:
Rush Copley Memorial Hospital		14-0029
Street:		**Medicaid Provider Number:**
2000 Ogden Avenue		1007
City:	**State:**	**Zip:**
Aurora	IL	60504
Period Covered by Statement:	**From:**	**To:**
	07/01/2018	06/30/2019

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
[ ] Church	[ ] Individual	[ ] State	[ ] Township
[XXXX XXXX] Corporation	[ ] Partnership	[ ] City	[ ] Hospital District
[ ] Other (Specify)	[ ] Corporation	[ ] County	[ ] Other (Specify)

Type of Hospital

[XXXX XXXX] General Short-Term	[ ] Psychiatric	[ ] Cancer
[ ] General Long-Term	[ ] Rehabilitation	[ ] Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

[XXXX XXXX] Medicaid Hospital	[ ] Medicaid Sub II Rehab	[ ]
[ ] Medicaid Sub I Psych	[ ] Medicaid Sub III Other	[ ]

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Rush Copley Memorial Hospital 1007 for the cost report beginning 07/01/2018 and ending 06/30/2019 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):		Signed (Officer or Administrator of Provider(s)):
Name (Typewritten)		Name (Typewritten)
Title	Date	Title
Firm		Date
Telephone Number		Telephone Number
Email Address		Email Address

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Rev. 01 / 17

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	157	57,305		28,229	49.26%		11,118	3.21
2.	Psych								
3.	Rehab	18	6,570		4,352	66.24%		379	11.48
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,030		5,561	69.25%			
6.	Coronary Care Unit								
7.	NICU	13	4,745		1,920	40.46%			
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	25	9,150		7,682	83.96%			
22.	**Total**	**235**	**85,800**		**47,744**	**55.65%**		**11,497**	**3.48**
23.	Observation Bed Days				11,879				

Line No.	**Part II-Program**	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,012			3,224	1.18
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				584				
6.	Coronary Care Unit								
7.	NICU				202				
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				809				
22.	**Total**				**4,607**	**9.65%**		**3,224**	**1.18**

Line No.	**Part III - Outpatient Statistics - Occasions of Service**	**Program**	**Total Hospital**
1.	Total Outpatient Occasions of Service		

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

Preliminary

Medicare Provider Number:	Medicaid Provider Number:		
14-0029	1007		
Program:	Period Covered by Statement:		
Medicaid Hospital	From: 07/01/2018	To:	06/30/2019

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	17,429,122	164,501,156	0.105951	1,874,045		198,557	
2.	Recovery Room	1,808,668	20,734,584	0.087230	123,111		10,739	
3.	Delivery and Labor Room	11,413,950	31,510,580	0.362226	2,311,385		837,244	
4.	Anesthesiology	964,809	22,880,216	0.042168	312,279		13,168	
5.	Radiology - Diagnostic	14,044,639	201,189,328	0.069808	1,412,976		98,637	
6.	Radiology - Therapeutic	9,394,549	28,943,360	0.324584	11,551		3,749	
7.	Nuclear Medicine							
8.	Laboratory	13,433,904	139,476,897	0.096316	2,866,576		276,097	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	4,145,036	30,363,427	0.136514	1,697,288		231,704	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,292,387	47,335,297	0.069555	448,148		31,171	
17.	EEG							
18.	Med. / Surg. Supplies	17,822,827	83,339,288	0.213859				
19.	Drugs Charged to Patients	28,221,619	221,324,497	0.127512	3,501,603		446,496	
20.	Renal Dialysis	1,218,010	6,415,901	0.189842	209,545		39,780	
21.	Ambulance							
22.	Same Day Surgery	4,259,244	19,875,378	0.214298	13,312		2,853	
23.	G.I. Lab	4,987,881	18,015,232	0.276870	114,641		31,741	
24.	Cardiac Rehab	2,474,029	3,406,179	0.726336				
25.	Rehab Services	7,099,316	44,493,702	0.159558	286,175		45,662	
26.	Implantable Devices	14,031,086	41,810,315	0.335589				
27.	Pancreas Acquisition							
28.	Wound Care Center	1,111,787	5,694,365	0.195243				
29.	MCAI	5,245,114	26,028,933	0.201511				
30.	Vascular Services	6,361,151	47,221,386	0.134709	379,676		51,146	
31.	Diabetic Center	453,616	316,520	1.433135	336		482	
32.	Yorkville	8,681,283	62,285,528	0.139379	47,337		6,598	
33.	Endrocrinology	1,394,972	1,356,632	1.028261				
34.	MRI	1,871,517	23,423,218	0.079900	270,037		21,576	
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	3,815,325	17,047,966	0.223799	48,888		10,941	
44.	Emergency	16,160,698	148,519,901	0.108812	850,945		92,593	
45.	Observation	15,174,947	19,992,808	0.759020				
46.	**Total**				**16,779,854**		**2,450,934**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:			
14-0029			1007	
Program:	Period Covered by Statement:			
Medicaid Hospital	From:	07/01/2018	To:	06/30/2019

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	51,225,540		3,862,107	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	40,108		4,352	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,277.19		887.43	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,012			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,846,896			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	3,846,896			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	8,263,777	5,561	1,486.02	584	867,836
9.	Coronary Care Unit					
10.	NICU	6,820,339	1,920	3,552.26	202	717,557
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery		7,682		809	
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,450,934
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**7,883,223**

Hospital Statement of Cost

Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program

Preliminary

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense BHF Page 6(a)

Preliminary

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	304,408	164,501,156	0.001850	1,874,045		3,467	
2.	Recovery Room							
3.	Delivery and Labor Room	1,264,986	31,510,580	0.040145	2,311,385		92,791	
4.	Anesthesiology	3,750	22,880,216	0.000164	312,279		51	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic	800	28,943,360	0.000028	11,551			
7.	Nuclear Medicine							
8.	Laboratory	70,000	139,476,897	0.000502	2,866,576		1,439	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	198	30,363,427	0.000007	1,697,288		12	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Same Day Surgery							
23.	G.I. Lab							
24.	Cardiac Rehab	1,148,120	3,406,179	0.337070				
25.	Rehab Services							
26.	Implantable Devices							
27.	Pancreas Acquisition							
28.	Wound Care Center	18,000	5,694,365	0.003161				
29.	MCAI							
30.	Vascular Services							
31.	Diabetic Center							
32.	Yorkville							
33.	Endrocrinology							
34.	MRI							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	577,745	148,519,901	0.003890	850,945		3,310	
45.	Observation							
46.	**Ancillary Total**						**101,070**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number:	Medicaid Provider Number:	
14-0029	1007	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 07/01/2018	To: 06/30/2019

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	421,842	40,108	10.52	3,012		31,686	
48.	Psych							
49.	Rehab	84,308	4,352	19.37				
50.	Other (Sub)							
51.	Intensive Care Unit	831,809	5,561	149.58	584		87,355	
52.	Coronary Care Unit							
53.	NICU	165,300	1,920	86.09	202		17,390	
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**136,431**	
68.	**Ancillary Total (from line 46)**						**101,070**	
69.	**Total (Lines 67-68)**						**237,501**	

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0029	1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	7,883,223	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)	237,501	
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	95,511	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**8,216,235**	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	16,779,854	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	7,850,149	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,520,348	
	F. Coronary Care Unit		
	G. NICU	1,860,988	
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	28,011,339	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		19,795,104
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0029	1007
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	8,216,235	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	8,216,235	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
6.	**Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)**	**8,216,235**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	**Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)**		

* Line 9 DOES NOT APPLY to the Medicaid program.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:		
14-0029	1007		
Program:	Period Covered by Statement:		
Medicaid Hospital	From: 07/01/2018	To:	06/30/2019

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	19,795,104
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended to (1)	to (2)	to (3)	Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient Ratio (2A)	Inpatient Amount (Col. 1x2A) (2B)	Outpatient Ratio (3A)	Outpatient Amount (Col. 1x3A) (3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
14-0029	**1007**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 07/01/2018 To: 06/30/2019**

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
6.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7.	Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))**				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	**Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)**				

Hospital Statement of Cost / Graduate Medical Education Expense **BHF Supplement No. 2(a)**

Preliminary

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	53,703	164,501,156	0.000326	1,874,045		611	
2.	Recovery Room							
3.	Delivery and Labor Room	139,630	31,510,580	0.004431	2,311,385		10,242	
4.	Anesthesiology							
5.	Radiology - Diagnostic	10,741	201,189,328	0.000053	1,412,976		75	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	64,445	6,415,901	0.010045	209,545		2,105	
21.	Ambulance							
22.	Same Day Surgery							
23.	G.I. Lab	10,741	18,015,232	0.000596	114,641		68	
24.	Cardiac Rehab	96,667	3,406,179	0.028380				
25.	Rehab Services							
26.	Implantable Devices							
27.	Pancreas Acquisition							
28.	Wound Care Center							
29.	MCAI							
30.	Vascular Services							
31.	Diabetic Center							
32.	Yorkville							
33.	Endrocrinology							
34.	MRI							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	53,703	148,519,901	0.000362	850,945		308	
45.	Observation							
46.	**Ancillary Total**						**13,409**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0029	1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	1,063,342	40,108	26.51	3,012		79,848	
48.	Psych							
49.	Rehab	128,889	4,352	29.62				
50.	Other (Sub)							
51.	Intensive Care Unit	21,481	5,561	3.86	584		2,254	
52.	Coronary Care Unit							
53.	NICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**82,102**	
68.	**Ancillary Total (from line 46)**						**13,409**	
69.	**Total (Lines 67-68)**						**95,511**	

Hospital Statement of Cost

Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0029	1007
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,798		3,798
Newborn Days	809		809
Total Inpatient Revenue	28,011,339		28,011,339
Ancillary Revenue	16,779,854		16,779,854
Routine Revenue	11,231,485		11,231,485
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Page 2 - facility reports Nursery Days but did not reflect costs or charges on Worksheet C columns 1 & 8 of Medicare report. Also, didn't report any Nursery Customary Charges on BHF page 7.

Rev. 10 / 11